U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 29 September 2006

Case No.: 2006-BLA-05021

IN THE MATTER OF:

K.O.,
Claimant,

v.

PEABODY COAL CO.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES: K.O., in pro se
For the Claimant

Richard H. Risse, Esquire
For the Employer

BEFORE: John Vittone
Chief Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for Benefits under the Black Lung Benefits Act, Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, at 30 U.S.C. §901 *et seq.* (Act), and the implementing regulations at 20 C.F.R. §§ 718 and 725 (2005).[1] The Black Lung Benefits Act is designed to compensate those miners who have acquired pneumoconiosis, commonly referred to as "black lung disease," while working in our Nation's coal mines. Those miners who have worked in or around mines and have inhaled coal mine dust over a period of

[1] Section 718 of Title 20 of the Code of Federal Regulations is applicable to the current claim, as it was filed after March 13, 1980, and the regulations amended as of December 20, 2000 (hereinafter "new regulations") are also applicable, as the current claim was filed after January 19, 2001. 20 C.F.R. §§ 718.2, 725.2.

time, may contract black lung disease. This disease may eventually render the miner totally disabled or contribute to his death.

A formal hearing was held on March 15, 2006, in Phoenix, Arizona, at which I admitted into the record Director's Exhibits (*DX*) 1-30, Claimant's Exhibits (*CX*) 1-6, and Employer's Exhibits (*EX*) 1-9.[2] On June 7, 2006, the Employer filed its post-hearing brief. Claimant filed his on April 13, 2006 and again on August 10, 2006.[3] The decision in this matter is based upon testimony at the hearing (*Tr.*), documentary evidence admitted into the record at the hearing, and the post-hearing arguments of the parties.

PROCEDURAL HISTORY

The Claimant, K.O., filed his first claim for benefits on August 3, 1993. *DX 1*. The District Director, Office of Workers' Compensation Programs (District Director), denied benefits on October 28, 1993. *Id.*. The District Director denied benefits because the Claimant failed to show that he had pneumoconiosis, that the disease was caused at least in part by coal mine work, and that he was totally disabled by the disease. *Id.*

Claimant filed his second claim for benefits on February 24, 1997. The District Director denied benefits on May 28, 1997, because Claimant abandoned his claim. *DX 2*.

Claimant filed his third claim for benefits on August 27, 2002. The District Director denied benefits on May 21, 2003, because Claimant abandoned his claim. *DX 3*.

Claimant then filed the present claim for benefits on September 1, 2004, alleging a change in his condition pursuant to 20 C.F.R. § 725.309(d). *DX 5*. In a Proposed Decision and Order dated June 3, 2005, the District Director concluded that the Employer is the Responsible Operator, but denied entitlement to benefits for failure to establish any element of entitlement. *DX 25*. Claimant subsequently requested a hearing before the Office of Administrative Law Judges. *DX 26*. The claim was assigned to me, and I conducted a formal hearing on March 15, 2006, in Phoenix, Arizona.

ISSUES PRESENTED FOR ADJUDICATION AND STIPULATIONS

The issues listed as contested on the Form CM-1025 are as follows:

[2] Prior to the hearing, Employer requested to review Claimant's Exhibit 1, an x-ray taken October, 28, 2005. Claimant was unable give Employer the x-ray until the day of the hearing. I allowed Employer additional time to review Claimant's Exhibit 1 and submit a rebuttal interpretation, which is permitted under 20 C.F.R. § 725.414(a)(2)(ii). *Tr. p 8-10*. Employer submitted its rebuttal reading on April 18, 2006, and it was admitted into evidence as Employer's Exhibit 9.

[3] Upon receiving Employer's exhibit 9, I issued an order extending time for Claimant to respond to the new exhibit. On August 10, 2006, Claimant resubmitted a closing statement identical to the one he submitted in April.

(1) whether the evidence establishes a material change in conditions per 20 C.F.R. § 725.309(c), (d);
(2) whether the miner suffers from pneumoconiosis;
(3) whether the miner's pneumoconiosis arose out of coal mine employment;
(4) whether he is totally disabled from a pulmonary or respiratory standpoint;
(5) whether the miner's total disability is due to pneumoconiosis.

DX 28.

The parties have stipulated, and I find based on the record, that the Claimant was employed in the coal mines for 14 years.[4]

CLAIMANT'S TESTIMONY AT THE HEARING

At the hearing, Claimant testified he began working in the Employer's coal mines in 1973, when he was eighteen (18) years old. *Tr. 17 & 27*. Over the course of his fourteen years with Employer, Claimant worked at a variety of positions but nearly all were located at the face of the mines. *Tr. 20.* Claimant testified that he was a shuttle car operator during his last four years working in the coal mines. *Id.* The position required hauling coal from the face of the mine to the beltline.[5] *Tr. 14*. Claimant explained that he spent half of his shift sitting, and lifted between twenty and sixty pounds for a distance of ten or twenty feet at a time.[6] *Tr. 29*.

Claimant testified that he started experiencing shortness of breath around 1980. *Tr. 13.* He has been treated by several doctors for Chronic Obstructive Pulmonary Disease (COPD) since 1981, beginning with Dr. Shelby Hughes Siad. *Id.* Claimant testified that by 1992, he was unable to perform several of his coal mining job duties. *Tr. 14*. He explained that he had to stop working sometimes because he had difficulty breathing when he had to do manual labor such as shoveling coal. *Id*. In 1997, four years after he was totally disabled in an accident in the mines,[7] Claimant's pulmonologist, Dr. William Houser, suggested he move to a dry climate in order to improve his respiratory condition. *Id.* Claimant moved to Arizona in 1998 and testified that the new climate has helped him. *Id*.

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[4] Claimant indicated that he had worked in the coal mines for around eighteen years in each of his four claims. *See DX 1-3 and 6*. In the decision on the first claim, the Director found that Claimant worked in coal mines for fourteen years. *DX 1*. In his findings on the present claim, the Director again found that Claimant worked in coal mines for fourteen years. *DX 25*. When Complainant requested a formal hearing before the Administrative Law Judge, both the Director and Employer contested Complainant's claim of working for 18 years in the coal mines. *DX 28*. At the hearing, Claimant stipulated that he worked in the coal mines for fourteen years. *Tr. 17 & 35.* Employer also stipulated to Claimant working in the mines for fourteen years. *Tr. 34.*

[5] In his Description of Coal Mine Work and Other Employment (Form CM-913), Claimant indicated that the shuttlecar operator position also entailed hanging vent curtains and cables, and moving loading and mining machines. *DX 7*.

[6] Claimant testified he worked nine or ten hour shifts, as well as overtime. *Tr. 28.*

[7] In 1993, Claimant was totally disabled when an airlock door closed on his upper body while he was working in the mines. *Tr. 14 & 23.* Claimant received a workers' compensation settlement for his injuries. *Tr. 33*.

Claimant testified that his condition has deteriorated to the degree that performing tasks such as putting on his clothes or walking ten steps leaves him gasping for air and experiencing chest pains. *Tr. 15 & 20*. He explained that he has to sleep with pillows under his upper body and is awakened three or four nights per week, gasping for air and experience cold sweats and chest pains. *Tr. 15*. Claimant also often experiences cold and flue symptoms consisting of coughing and phlegm. *Id*. He uses a nebulizer with Albuterol at least twice daily, uses two inhalers, and takes Singulair. *Tr. 21*. Claimant also uses Oxycontin and Hydrocodone for pain relating to his disabling back injury. *Tr. 21-22*. Claimaint testified that he has not been hospitalized for his respiratory condition since 1993. *Tr. 22*. Claimant has been treated by Dr. Evanson, his primary care physician, since either 1998 or 1999, and also sees Dr. Tadloff for pain management care relating to his back injury. *Tr. 24-25*.

Claimant testified that he has smoked off and on for years, quitting for a few weeks or years at a time. *Tr. 16*. Claimant explained that he stopped smoking for three years once. *Tr. 28*.[8]

DISCUSSION

Subsequent Claim Threshold Issue

To prevail in a claim for Black Lung Benefits, Claimant bears the burden of establishing each of the following elements by a preponderance of the evidence: (1) he suffers from pneumoconiosis; (2) arising out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. 20 C.F.R. § 718 (2005); *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986)(en banc); *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65 (1986)(en banc).

The instant claim is a subsequent claim because it was filed more than one year after the denial of a prior claim for benefits. There is, accordingly, a threshold issue as to whether there are grounds for reopening the claim under 20 C.F.R. § 725.309. A subsequent claim will be denied unless Claimant can demonstrate a change in at least one condition of entitlement previously adjudicated against him. 20 C.F.R. §§ 725.309(d)(2), (3). If a claimant demonstrates a change in one of the applicable conditions of entitlement, then findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309(d)(4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

Claimant's prior claim was finally denied for failure to establish the existence of pneumoconiosis arising from coal mine employment and total disability due in part to his pneumoconiosis. 20 C.F.R. §§ 718.202 - 718.204. *DX 1*. Thus, for purposes of adjudicating the present subsequent claim, the newly submitted evidence must establish that Claimant now suffers from pneumoconiosis or totally disabling pulmonary impairment.

[8] There are discrepancies in the record as to how much Claimant smoked. It ranges from ¼ pack per day (*DX14*) to two packs per day (*CX4*).

I. Existence of Pneumoconiosis and its Etiology

Under the amended regulations, "pneumoconiosis" is defined to include both clinical and legal pneumoconiosis:

> (a) For the purpose of the Act, "pneumoconiosis" means "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. The definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2005). The regulations at 20 C.F.R. § 718.203(b) (2005) also provide that, if a miner suffers from pneumoconiosis (as established by a chest x-ray) and has engaged in coal mine employment for ten years or more, there is a rebuttable presumption that the pneumoconiosis arose out of such employment.

The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a) (2005).

A. Chest X-Ray Evidence

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classifications of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record. *Clark v. Karst-Robbins Coal Co.,* 12 B.L.R. 1-149 (1989)(en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986).

When weighing chest x-ray evidence, the provisions at 20 C.F.R. § 718.202(a)(1) require that "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays."[9] The Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). The following chest roentgenogram evidence is in the record:

Exhibit #	Date of X-Ray	Date of Reading	Physician/ Radiological Qualifications	Film Quality	Interpretation
CX 4	11/9/96	11/9/96	Dr. Bouffard/ No Qualifications Given (hospital treatment X-Ray)	Readable	Normal chest unchanged compared to previous examinations
DX 14	11/8/04	11/18/04	Dr. Pfisterer/Board-certified radiologist, B-reader	1	Negative for pneumoconiosis
DX 15	11/8/04	1/13/05	Dr. Navani/Board-certified radiologist, B-reader	1	Quality Reading Only

[9] A B-reader is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. An A-reader is a physician, but not necessarily a radiologist, who submitted six x-ray studies of his or her clients to ALOSH of which two studies are interpreted as positive for the existence of pneumoconiosis, two studies are negative, and two studies demonstrate complicated pneumoconiosis.

DX 16[10]	11/8/04	3/27/05	Dr. Wiot/Board-certified radiologist, B-Reader	1	Negative for pneumoconiosis
CX 1	10/28/05	2/10/06	Dr. Mark Schiefer, MD, MPH, MS/B-reader	1	1/0,[11] s, p Small Opacities no large opacities no pleural abnormalities consistent with pneumoconiosis
EX 9[12]	10/28/05	3/29/06	Dr. Wiot/Board-certified radiologist, B-reader	2 (overexposed and underexposed)	Negative for Parenchymal and pleural abnormalities Other abnormalities: cg
EX 1	11/4/05	11/4/05	Dr. Repsher/B-reader	1	Negative for pneumoconiosis
EX 2	11/4/05	12/19/05	Dr. Wiot/Board-certified radiologist, B-reader	2 ("distal *illegible")*	Negative for pneumoconiosis

Based on the foregoing, Claimant has not established that he suffers from coal miners' pneumoconiosis. Of the submitted evidence, there are seven interpretations of four x-rays.[13] Four of the seven interpretations were completely negative for any abnormalities associated with coal miner's pneumoconiosis.[14] Three of the four physicians who interpreted Claimant's x-rays as completely negative for pneumoconiosis were dually-qualified, Board-certified radiologists and B-readers. *DX 14 & 16; EX 2.* The fourth physician providing a negative interpretation was a B-reader. *EX 1.*

One interpretation, by Dr. E. V. Bouffard, did not specifically address whether Claimant had pneumoconiosis, but indicated that Claimant's lungs were normal. *CX 4.* This 1996 x-ray was not read specifically for pneumoconiosis diagnosis purposes, but the detailed notations describing the x-ray indicate no abnormalities that would be associated with pneumoconiosis. *CX 4.* Dr. Bouffard noted that Claimant's x-ray showed no evidence of chamber enlargement;

[10] Employer submitted Dr. Wiot's reading of the November 8, 2004, x-ray to the Director on April 13, 2005. In the past, this exhibit would not have been admissible under the provisions at 20 C.F.R. § 725.414(a)(2) (2001). Under *Sprague v. Freeman United Coal Mining Co.*, BRB 05-1020 BLA (Aug. 31, 2006), a party opposing entitlement can "respond to a particular item of evidence in order to rebut 'the case presented by the party opposing entitlement.'" *Sprague* at 5-6. Therefore, Employer is allowed to bolster Dr. Pfister's negative interpretation of the November 8th x-ray by providing its own negative interpretation.

[11] Dr. Shiefer categorized the profusion as 1/0 in the chart but wrote 1/1 in his comments about the interpretation. This does not change the outcome of the case.

[12] Submitted by Employer in rebuttal to Claimant's Exhibit 1, pursuant to 20 C.F.R. § 725.414(a)(3)(ii).

[13] I have omitted the quality-only interpretation by Dr. Navani (*DX 15*) because it does not address the issue of whether Claimant has pneumoconiosis.

[14] *DX 14 & 16; EX 1 & 2.*

no abnormal cardiac calcification; unremarkable thoracic aorta, mediastinal & bronchiovascular structures; symmetrical pulmonary vasculature; no evidence of active disease in the lung parenchymal; no chronic lung changes; no pleural effusions or pleural abnormality; and normal bony thoracic cage. *CX 4*. Dr. Bouffard made no pneumoconiosis determination. *CX 4.*

Of the two remaining x-ray interpretations, both of which noted abnormalities, only one indicates that Claimant has pneumoconiosis. *CX 1; EX 9.* Dr. Mark Schiefer, a B-reader, provided an explanatory notation along with his positive interpretation in which he found parenchymal and other abnormalities. *CX 1.* He noted that Claimant had "slightly prominent pulmonary artery outflow tracts, small right apical granulocalcific changes, and slightly increased bronchovascular markings [consistent with] mild COPD." *CX 1*. Dr. Schiefer also noted that Claimant had "s/s profusion 1/1[15] right lower lung zone [consistent with] mixed obstructive and interstitial lung disease." *CX 1.*

Dr. Jerome F. Wiot, a Board-certified radiologist and B-reader, interpreted the same x-ray as Dr. Schiefer and explained his findings in an accompanying letter. *EX 9*. He explained that there was no evidence of coal workers' pneumoconiosis. *EX 9.* "There is a single nondescript nodule superimposed over the right clavicle and first rib which appears calcified and most likely represents a granuloma. This is not a manifestation of coal dust exposure." *EX 9.*

The single positive interpretation by Dr. Shiefer is outweighed by the overwhelming x-ray evidence indicating that Claimant does not have pneumoconiosis. Dr. Wiot is a dually qualified physician (Board-certified radiologist and B-reader) and, as a result, his interpretation of the same x-ray may be afforded more weight than Dr. Shiefer's interpretation. *Zeigler Coal Co. v. Director, OWCP [Hawker]*, 326 F.3d 894 (7th Cir. 2003); *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999)(en banc on recon.). Additionally, two interpretations of an x-ray taken within a week of Dr. Shiefer's positive interpretation indicate that Claimant does not have pneumoconiosis. *EX 1 & 2.*

Given that the lone positive interpretation was contradicted four times by dually-qualified physicians and once by a B-reader, I find that the Claimant has failed to established by a preponderance of the x-ray evidence the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(1).

B. Biopsy Evidence

Pursuant to 20 C.F.R. § 718.202(a)(2), Claimant may establish pneumoconiosis through the use of biopsy evidence. Since no such evidence was submitted, pneumoconiosis is not established in this manner.

[15] Dr. Shiefer categorized the profusion as 1/0 in the chart but wrote 1/1 in his comments about the interpretation. This does not change the outcome of the case.

C. Operation of Presumption

There is no evidence that Claimant suffers from complicated pneumoconiosis; therefore, he is not entitled to the irrebuttable presumption set forth at 20 C.F.R. § 718.304.

D. Sound Medical Judgment[16]

The final method by which Claimant may establish that he suffers from pneumoconiosis is by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra*. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988). The following medical reports were admitted as evidence in the record:

1. Dr. William C. Houser, whose qualifications are not of record but who is associated with Evansville Pulmonary Associates, Inc., cared for Claimant from October 14, 1997, through February, 1998. *CX 4.* Dr. Houser based his opinion on his own examination of Claimant, a chest x-ray interpretation, and pulmonary function studies. *Id.*

In his report on Claimant's initial office visit in 1997, Dr. Houser noted that Claimant smoked between one and two packs of cigarettes per day for 25 years and worked in coal mines for 20 years. *Id.* He listed Claimant's job titles but did not discuss Claimant's job duties or physical exertion requirements. *Id.* Claimant complained of respiratory problems that began seven to eight years earlier. *Id*. Claimant said he did not normally experience wheezing but had chest pains along the lower left anterior chest wall that are aggravated by deep breathing and coughing. *Id.* Claimant reported that he uses two inhalers – Atrovent and Proventil. *Id.*

[16] Claimant's medical records from Kingman Regional Medical Center are of record as Employer's Exhibit 6. The records date from July 2001 to June 7, 2004 and deal almost entirely with medical concerns other than respiratory problems. One x-ray report from July 28, 2001 notes that Claimant's "[h]eart size and mediastinum are normal. Lungs are clear." The impression was "no acute cardiopulmonary disease." *EX 6 at 103*.

Dr. Houser reviewed the November 9, 1996, x-ray interpretation by Dr. Bouffard and determined that it was within the normal limits. *CX 4.* Claimant had a regular cardiac rhythm. *Id*. Dr. Houser also administered a pulmonary function test and noted that the spirometry showed that Claimant had "moderately severe airway obstruction," and that there was "modest improvement" after a bronchodilator was administered. *Id.* Lung volume studies showed "normal total lung capacity was mild reduction in the vital capacity [sic]." *Id.* Dr. Houser also noted moderate reduction in the single breath diffusing capacity.[17] *Id*. Dr. Houser concluded that Claimant had a disabling respiratory impairment "which would prevent him from physically being able to perform his prior employment as a coal miner." *Id.* Dr. Houser diagnosed Claimant with chronic bronchitis and recommended that he go to the Black Lung Clinic for a complete pulmonary function test. *Id.* Dr. Houser also recommended that Claimant stop smoking. *Id*.

2. Dr. Scott Hardy, Board certified in occupational medicine and toxicology,[18] examined Claimant on November 8, 2004, and issued a report on January 3, 2005. *DX 14*. Dr. Hardy based his opinion upon pulmonary function studies performed by Dr. James Lawrence[19], arterial blood gas studies, Dr. William Pfisterer's x-ray interpretation, and his own examination of Claimant.

In his exam report, Dr. Hardy noted that Claimant worked in the coal mines for twenty years and started smoking in 1965 or 1966 and stopped smoking in February, 2004. *DX 14*. Claimant smoked Marlboro cigarettes at a rate of a quarter of a pack, or about five cigarettes per day. *Id*. He noted that Claimant has been treated for asthma since 1982 and also has chronic bronchitis. *Id*. At the time of the evaluation, Claimant experienced sputum, wheezing, and coughing on a daily basis. *Id*. Claimant also experienced chest pain once a week and orthopnea and paroxysmal nocturnal dyspnea. *Id.* Dr. Hardy noted that Claimant's pulmonary function studies results were inconclusive because of pain relating to his back injury. *Id*. Claimant's arterial blood gas studies indicated "normal oxygenation and saturation" that was "improved with exercise" and "slight alkalosis following walking." *Id*. Claimant's EKG indicated a normal sinus rhythm with an "incomplete right bundle branch block." *Id*.

Based on his examination and test results, Dr. Hardy diagnosed Claimant with Chronic Obstructive Pulmonary Disease (COPD) as indicated by Claimant's pulmonary function studies and medical history, which includes chronic bronchitis and obstructive lung disease. *DX 14.* Dr. Hardy concluded that the primary cause of Claimant's COPD was cigarette smoking and asthma. *Id*. Dr. Hardy concluded that Claimant is severely impaired by a combination of his COPD and from his back and leg pain. *Id*. Dr. Hardy stated that "the impairment would preclude coal

[17] There are no spirommetric tracings or flow-volume loops on record for this pulmonary function study.

[18] Curriculum vitae was not attached. Qualifications in Employer's brief.

[19] Dr. Hardy noted that the November 17, 2004, pulmonary function studies were incomplete because Claimant had a cold and was experiencing pain from his back injury. *DX 14.* He had opportunity to review the February 5, 2005, pulmonary function studies conducted by Dr. Lawrence and made no changes to his diagnosis that Claimant does not have pneumoconiosis.

mining for either the lung disease or back/leg condition if either were present alone." *Id*. Claimant is "severely impaired" by his COPD and any activity besides sedentary work "are impaired." *Id*.

3. Dr. Jeffery Evenson, a doctor of internal medicine whose qualifications are not of record, wrote two letters in support of Claimant. *DX 17; CX 5*. In the first letter, dated May 9, 2005, Dr. Evenson stated that Claimant worked in coal mines for 15 years and "has been disabled from Black Lung Disease since the early 1980's." *DX 17*. Dr. Evenson did not address Claimant's specific coal mining job duties or exertion requirements. *Id.* Dr. Evenson opined that Claimant's COPD is secondary to Black Lung disease and that Claimant's x-rays were consistent with Black Lung Disease. *Id.* Dr. Evenson "feel[s] that [Claimant] has Black Lung Disease and is 100% disabled from [it]." *Id*.

In his second letter, dated January 20, 2006, Dr. Evenson reiterated that he believes Claimant has pneumoconiosis based on examination and previous breathing studies. *CX 5*. Dr. Evenson claims he bases his opinion on medical records that begin in 1981, as well as Claimant's employment history. *Id*. Dr. Evenson concluded that "coalmine dust is the main cause and only cause of [Claimant's] Black Lung Disease" and that Claimant is "totally disabled from doing any type of employment because of the black lung disease and obviously he could not perform the work required of a coal miner." Dr. Evenson did not discuss any of the medical evidence that led him to these conclusions. *CX 5; DX 17.*

4. Dr. Lawrence Repsher examined and tested Claimant on November 4, 2005, reviewed certain medical records, and issued a report on November 29, 2005. *EX 1; Tr. 39*. He is Board-certified in internal medicine with a sub-specialty in pulmonary diseases and is also a NIOSH certified B-reader. *Tr. 39.* Dr. Repsher based his opinion on x-ray evidence, pulmonary function studies, arterial blood gas tests, physical examination, and a CT scan.

Dr. Repsher noted that Claimant worked in the mines for almost 15 years, with his final job being a shuttlecar operator, and that he has been unable to return to work since 1993 because of chronic back pain. *EX 1*. He reported that Claimant began smoking up to one pack of cigarettes per day when he was a teenager but quit about two years before the examination. *Id*. Claimant complained of a history of progressive dyspnea on exertion, coughing, atypical chest pains, severe orthopnea, and asthma. *Id*. Upon examination, Dr. Repsher observed that Claimant had decreased breath sounds and that his expiratory phase was not prolonged. *Id*. Dr. Repsher observed no "rales, rhonchi, or wheezes, even with forced expiration." *Id*.

Dr. Repsher interpreted Claimant's chest x-ray as "show[ing] no evidence of coal workers' pneumoconiosis," rated as a Category 0 and described as "entirely normal." *EX 1*. Claimant's noncontrast, high-resolution CT scan was also normal.[20] *Id.* Dr. Repsher noted that Claimant's pulmonary function studies were "probably within normal limits, when adjusted for

[20] Dr. Jerome F. Wiot, Board-certified radiologist, interpreted Claimant's CT scan. *EX 3*. Dr. Wiot stated "there is no evidence of coal workers' pneumoconiosis. There are findings consistent with emphysema. There is a single nondescript nodule in the right apex [which is] not a manifestation of coal dust exposure." *Id*.

poor effort and cooperation, except for a mild to moderate reduced diffusing capacity, overwhelmingly most likely due to his long and heavy cigarette smoking habit."[21] *Id.* Dr. Repsher testified at the hearing that Claimant's impaired diffusing capacity is associated with centrilobular emphysema, which is caused by cigarette smoking. *Tr. 44.* Coal mine dust causes focal emphysema, which is not associated with impaired diffusing capacity. *Tr. 44.* Dr. Repsher also noted that Claimant's arterial blood gas tests were normal at rest and that blood testing indicated that Claimant was still smoking cigarettes at the time of the examination. *EX 1; Tr. 43*. Claimant's echocardiogram showed "mild left ventricular hypertrophy (LVH), which would suggest the potential for diastolic dysfunction." *EX 1*.

Dr. Repsher concluded that Claimant showed "no evidence of either medical or legal pneumoconiosis," or "any other pulmonary or respiratory disease or condition, either caused by or aggravated by his employment as a coal miner with exposure to coal mine dust." *EX 1.* Claimant has "moderate centrilobular emphysema, due to cigarette smoking" and probably has coronary artery disease that is "complicated by ischemic cardiomyopathy, with symptoms of left ventricular congestive heart failure." *Id.* Claimant's radiographic and histologic evidence, pulmonary function studies, arterial blood gas tests were all negative for pulmonary impairment. *Id.* Dr. Repsher determined that Claimant has "no pulmonary impairment" and that from a respiratory point of view, he is "fully fit . . . to perform his usual coal mine work or work of a similarly arduous nature in a different industry." *Id.*

5. Dr. Joseph J. Renn, a Board-certified pulmonary specialist and B-reader, conducted a review of Claimant's medical records and issued a medical report on February 9, 2006. *EX 4; EX 8.* Dr. Renn was deposed on March 13, 2006. *EX 8.* Dr. Renn noted that Claimant worked as a coal miner off and on over the course of twenty years and had smoked between ten and thirty-one packs of cigarettes per year. *EX 4*.

Based on his review of the records, Dr. Renn determined that Claimant has "chronic bronchitis and pulmonary emphysema owing to tobacco smoking; however, it may also be that he has an incomplete expression of alpha-1 antitrypsin deficiency thus, also, acting as an etiology for his pulmonary emphysema." *EX 4*. Dr. Renn opined that Claimant does not have either medical or legal pneumoconiosis and that he is not totally and permanently disabled "to the extent that he would be unable to perform his last known coal mining job of shuttle car operator or any similar work effort." *Id.* Dr. Renn noted in his deposition that several things led him to this conclusion. Claimant's lung volume studies showed an increase in lung volume, which "is the exact opposite of what occurs in coal workers' pneumoconiosis" and is consistent with COPD, chronic bronchitis, and emphysema that develops because of tobacco smoking. *EX 8 at 6 & 10.* He also noted that all but one x-ray interpretation "assigned perfusion categories of 0/0 for coal workers' pneumoconiosis" and that Dr. Shiefer's interpretation, which excluded the left upper lung zone when noting opacities, was inconsistent with coal miner's pneumoconiosis. *EX 8 at 7.*

[21] Dr. Repsher testified that the low volume loop indicated that Claimant did not give full effort during the test because of his neck and back pain. *Tr. 45*.

Discussion of the medical opinions

Of the physicians' reports of record, only Dr. Evenson's concluded that Claimant suffers from coal workers' pneumoconiosis. Dr. Houser diagnosed Claimant with chronic bronchitis and suggested that Claimant visit a Black Lung Clinic and cease smoking. Drs. Hardy, Repsher, and Renn each stated that Claimant does not suffer from clinical or legal pneumoconiosis. Rather, they concluded that Claimant's respiratory impairment stems from Claimant's long-term tobacco abuse. For the following reasons, I find that Dr. Evenson's opinion is less probative, Dr. Houser's opinion is silent on the issue of pneumoconiosis, and Drs. Hardy, Repsher, and Renn's opinions are more probative.

Dr. Evenson's opinion carries little probative value because his report includes no underlying medical evidence and his qualifications are not of record. Dr. Evenson unequivocally states that Claimant has pneumoconiosis and is totally disabled, but he offers no medical evidence to support those claims, making only vague references to records, tests, and physical examinations. His diagnosis is not supported with medical evidence and is not reasoned. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984). *See also Phillips v. Director, OWCP,* 768 F.2d 982 (8th Cir. 1985)*; Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.*, 4 B.L.R. 1-601 (1982). In addition, Dr. Evenson also fails to take into account Claimant's extensive smoking history. *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993) (physician's opinion less probative where based on inaccurate smoking history).

Dr. Evenson offered no objective medical evidence to support his opinion, but Claimant's medical records while under his care are in the record as Employer's Exhibit 7. The vast majority of his interactions with Claimant has been related to his back and neck injuries and not for pulmonary problems. *EX 7.* In several portions of the record, Dr. Evenson notes that Claimant has COPD and prescribes various inhalers to treat it, but does not mention coal miners' pneumoconiosis. *EX 7* at 6-9, 29, 41. An x-ray taken July 22, 1999, shows bilateral pulmonary hyper-aeration with "no infiltrate, consolidation or effusion" (*EX 7 at 50)*; one taken September 10, 2001, indicates "peribronchial cuffing which may represent bronchitis or viral pneumonitis" *(EX 7 at* 47); one on June 16, 2003 shows "no interval signs of acute cardiopulmonary disease" (*EX 7 at 46*); and one taken September 13, 2004 indicates COPD only (*EX 7 at 45*). No reference to coal miners' pneumoconiosis is made. As a result, Dr. Evenson's report is internally inconsistent and inadequately reasoned and must, therefore, be given little weight. *Mabe v. Bishop Coal Co.,* 9 B.L.R. 1-67 (1986).

Dr. Houser's report is silent as to coal miners' pneumoconiosis and his qualifications are not in the record. As a result, his opinion is less probative than that of a physician whose qualifications are in the record. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). In his report, Dr. Houser considered Claimant's employment and social histories when he analyzed the data from Claimant's physical exam, x-rays, and pulmonary function studies. The underlying data upon which Dr. Houser relied was adequate to support his conclusion that Claimant has chronic bronchitis, but his report is silent as to whether Claimant has coal miners' pneumoconiosis. It is, therefore, not probative as to that issue. He considers pneumoconiosis as a possibility because

he recommends that Claimant visit the Black Lung Clinic, but this is not sufficient as a medical diagnosis. This recommendation is also based on an inaccurate history of Claimant's coal mine employment - reporting twenty years of coal mine experience rather than fourteen. Therefore, Dr. Houser's recommendation to visit a Black Lung Clinic holds less probative value than an opinion using the proper length of employment. *Worhach v. Director, OWCP,* 17 B.L.R. 1-105 (1993)(per curiam)(physician reported an eight year coal mine employment history, but the ALJ only found four years of such employment). Additionally, Dr. Houser coupled his recommendation to visit a Black Lung Clinic with the statement "[Claimant] obviously needs to quit smoking," which indicates that he also considered cigarette smoking to be a cause of Claimant's respiratory or pulmonary ailments.

Dr. Hardy, whose qualifications are of record,[22] considered extensive objective medical data as well as Claimant's work and social histories when he wrote his report. He incorrectly determined Claimant worked in coal mines for twenty years, but this mistake does not decrease the probative value of the report because he diagnosed Claimant with COPD caused by cigarette smoking and asthma, not pneumoconiosis. Dr. Hardy's opinion was supported by objective medical data because he considered x-rays, pulmonary function studies,[23] and arterial blood gas studies. On the other hand, Dr. Houser's report lacked blood gas studies and Dr. Evenson's report included no objective medical data at all. As a result, Dr. Hardy's opinion is accorded greater weight than Drs. Houser and Evenson's opinions. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n. 1 (1986); *Weitzel v. Director, OWCP,* 8 B.L.R. 1-139 (1985).

Similarly, Dr. Repsher determined that Claimant does not have coal miners' pneumoconiosis and diagnosed Claimant with "moderate centrilobular emphysema, due to cigarette smoking" and "probable coronary artery disease complicated by ischemic cardiomyopathy, with symptoms of left ventricular congestive heart failure." Dr. Repsher's opinion was well-reasoned and well-documented, with specific references to objective medical evidence.

Dr. Renn, whose qualifications are of record, relied on extensive medical history and objective tests to determine that Claimant does not suffer from pneumoconiosis. He consulted records dating back to 1993, when Claimant filed his first claim with the Director. He considered Claimant's employment and social histories, unrelated medical problems, medications, laboratory data, and physical exams. Dr. Renn's opinion is well-documented and well-reasoned and is supported by objective medical evidence.

In sum, given that Dr. Evenson's qualifications are unknown and his diagnosis of coal workers' pneumoconiosis is unreasoned and undocumented, his opinion is insufficient to demonstrate presence of the disease under the regulations. Dr. Houser did not specifically address the etiology of Claimant's lung impairment and his opinion is inconclusive on the source of Claimant's respiratory problems; therefore, it is less probative than those opinions that address

[22] He is described as a Board Certifed in Occupational Medicine in Employer's brief. No curriculum vitae is attached.

[23] The November 17, 2004 pulmonary function test that Dr. Hardy relied upon was later determined to be invalid, but Dr. Hardy also reviewed the February 8, 2005 pulmonary function test and made no changes to his diagnosis.

pneumoconiosis. Drs. Hardy, Repsher, and Renn conclude that Claimant does not suffer from clinical or legal pneumoconiosis and their findings are supported by a preponderance of the objective medical data, i.e. the negative chest x-ray studies and CT scan of record. *Minnic v. Pagnotti Enterprises, Inc.,* 9 B.L.R. 1-89, 1-90 n. 1 (1986) (it is proper to accord greater weight to an opinion that is better supported by objective medical data of record).

The opinions of Drs. Hardy, Repsher and Renn are accorded the greatest weight on this record than Dr. Evenson's because their qualifications are of the record. Each consulted objective medical evidence and data concerning Claimant's employment, social, and medical history. Dr. Renn considered medical evidence dating back to 1993 and reviewed a variety of hospitalization and treatment records as well as objective medical evidence obtained in connection to the current claim. *Sabett v. Director, OWCP*, 7 B.L.R. 1-299 (1984) (greater weight may be accorded an opinion that is supported by more extensive documentation).

Consequently, Claimant has not sustained is burden of demonstrating that he suffers from clinical or legal coal workers' pneumoconiosis under § 718.202(a) of the records. Therefore, he does not overcome the subsequent claim threshold on this issue.

II. Total Disability

Claimant may also overcome the subsequent claim threshold by establishing that he has a totally disabling respiratory or pulmonary condition. Benefits are provided under the Act for, or on behalf of, miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a) (2005). The regulations further state the following:

> For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

20 C.F.R. § 718.204(a) (2005).

Twenty C.F.R. § 718.204(b) (2005) provides the following five methods to establish total disability: (1) qualifying pulmonary function studies; (2) qualifying blood gas studies; (3) evidence of cor pulmonale with right-sided congestive heart failure; (4) reasoned medical opinions; and (5) lay testimony.[24]

[24] The Board holds that a judge cannot rely solely upon lay evidence to find total disability in a living miner's claim. *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994).

A. Pulmonary Function Studies

Total disability may be established through a preponderance of qualifying pulmonary function studies. The quality standards for pulmonary function studies are located at 20 C.F.R. § 718.103 and require, in relevant part, that (1) each study be accompanied by three tracings, *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984), (2) the reported FEV1 and FVC or MVV values constitute the best efforts of three trials, and, (3) for testing conducted after January 19, 2001, a flow-volume loop must be provided. The administrative law judge may accord lesser weight to those studies where the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984). To be qualifying, the regulations provide that the FEV1 be qualifying *and* either (1) the MVV or FVC values must be equal to or fall below those values listed at Appendix B for a miner of similar gender, age, and height, or (2) the result of the FEV1 divided by the FVC is equal to or less that 55 percent. The following pulmonary function studies are in the record:[25]

Exhibit	Date of Test	Physician	Age/ height (in)	Coop/ comp	Tracings/flow volume loop on record?	Broncho-dilator (pre/post)	FEV1 (pre/post)	FVC (pre/post)	Qualifies
CX 4	12/15/97	Houser	42/67.7	Not noted	No/No	Pre/post	1.80/2.02	3.49/3.50	No
DX 14	11/17/04	Lawrence	49/67.7	Not noted	Yes/Yes	Pre	1.13	1.48	Invalid Test[26]
DX 14	2/8/05	Lawrence	50/67.7	Not noted	Yes/Yes	Pre	2.14	3.56	No
EX 1	11/4/05	Repsher	50/67.7	Fair, coopera-tive but question-able	Yes/Yes	Pre/Post	2.80/2.82	3.89/3.71	No

Based upon the foregoing, the miner has not established total disability pursuant to 20 C.F.R. § 718.204(b)(2)(i) of the regulations. There are no qualifying pulmonary function studies of record. All but the 1997 test by Dr. Houser failed to qualify because both FEV1 and FVC levels were above the values in Appendix B of § 718. In the 1997 test by Dr. Houser, only the FEV1 value qualified, but the FVC value did not. None of the pulmonary function studies establish that Claimant has a total disability pursuant to § 718.204(b)(2)(i).

[25] The factfinder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP,* 6 B.L.R. 1-221 (1983). Claimant's recorded height varied slightly with each pulmonary function study, ranging from 66.5 inches to 68 inches. I averaged the various measurements and used 67.7 inches for the purposes of analyzing the results of the pulmonary function tests.

[26] Agency pulmonary consultant Dr. Timothy C. Kennedy, deemed these test results invalid because there was an "insufficient number of FVC, FEV1 or MVV tracings without explanation" and there was "[l]ess than optimal effort, cooperation and concentration." *DX 14*.

B. Arterial Blood Gas Studies

Total disability may also be established by qualifying blood gas studies under 20 C.F.R. § 718.204(b)(2)(ii). In order to be qualifying, the PO2 values corresponding to the PCO2 values must be equal to or less than those found at the table at Appendix C. The following blood gas studies are in the record:

Exhibit	Date of Test	Physician	Altitude (feet)	Resting/Exercise	PCO2	PO2	Qualifies?
DX 14	11/8/04	Hardy	0-2999	Resting/Exercise	42.4/33.0	86.8/101.9	No
EX 1	11/4/05	Repsher	0-2999	Resting	38.9	84.8	No

Based upon the foregoing, the miner has not demonstrated total disability pursuant to § 718.204(b)(2)(ii) of the regulations. Neither arterial blood gas test qualifies to establish that Claimant is totally disabled.

C. Cor Pulmonale with Right-Sided Congestive Heart Failure

There is no evidence of cor pulmonale with right-sided congestive heart failure, so Claimant has not established total disability under section 718.204(b)(2)(iii).

D. Medical Opinion Evidence and Lay Testimony

The final method by which Claimant may establish total disability is through medical opinion evidence wherein a physician has exercised reasoned medical judgment based on medically acceptable clinical and laboratory diagnostic techniques to conclude that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment or comparable employment. 20 C.F.R. § 718.204(b)(2)(iv) (2005).

Initially, Claimant has the burden of establishing the exertional requirements of his usual coal mine employment. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989). Once a claimant establishes that he is unable to perform his usual coal mine employment, a *prima facie* case for total disability exists and the burden shifts to the party opposing entitlement to prove that the claimant is able to perform comparable and gainful work. *Taylor v. Evans and Grambrel Co.*, 12 B.L.R. 1-83, 1-87 (1988).

Claimant appeared credible and testified at the hearing that he last worked as a shuttlecar operator in the coal mines. He described his job duties as including sitting for half of his shift and lifting between twenty and sixty pounds for a distance of ten or twenty feet at a time. Based on this record, it is determined that Claimant performed heavy manual labor. Comparing the exertional requirements of his last coal mining job with the physical limitations demonstrated on

this record, it is determined that Claimant has not established that he is totally disabled under 20 C.F.R. § 718.204(b)(2)(iv) through a preponderance of the medical opinion evidence of record.

Three of the medical opinions, by Drs. Evenson, Houser and Hardy, state that Claimant is totally disabled because of respiratory problems. The opinions by Drs. Repsher and Renn state that Claimant is not disabled from a respiratory standpoint and is capable of working at his previous coal mining employment. For the following reasons, I find that Drs. Repsher and Renn's opinions stating that Claimant is not disabled are more probative than those of Drs. Evenson, Hardy, and Houser.

Based on his treatment of Claimant in 1997 and 1998, Dr. Houser wrote a letter in 2005 diagnosing Claimant with a "disabling respiratory impairment which would prevent him from physically being able to perform his prior employment as a miner." *CX 4*. There is no indication that Dr. Houser treated Claimant after 1998 or that he viewed any recent medical evidence when coming to this conclusion. He also made his diagnosis despite objective medical evidence to the contrary and he did not explain his diagnosis in light of the nonqualifying ventilatory testing underlying his report. Claimant's chest x-ray was "within normal limits" and his pulmonary function studies failed to qualify. *Id.* His determination that Claimant has a "moderately sever airway obstruction" is based on the nonqualifying pulmonary function studies and he offers no other evidence support his rationale. It is also notable that Dr. Houser's qualifications are not of record, which makes his opinion less probative than a physician whose qualifications are available.

Dr. Evenson determined that Claimant is totally disabled from black lung disease and "obviously could not perform the work required of a coal miner." *CX 5.* As I discussed in a previous section, Dr. Evenson offers his opinion with no documentation to support it and I must, therefore, give it little weight. *Clark v. Karst-Robbins Coal Co.,* 12 B.L.R. 1-149 (1989)(en banc). Even when considering Dr. Evenson's medical records in Employer's Exhibit 7, I cannot determine the basis of his opinion. There is evidence that Claimant visited Dr. Evenson for respiratory problems, but there is no indication that he is totally disabled by those problems. Additionally, Dr. Evenson's qualifications are not of record. As a result, I must give Dr. Evenson's opinion little weight.

Dr. Hardy performed Claimant's Department of Labor exam and determined that Claimant suffers "severe impairment from COPD" which "would preclude coal mining employment." Dr. Hardy came to this conclusion despite one invalid and one non-qualifying pulmonary function study and a non-qualifying arterial blood gas study. Upon examination, Dr. Hardy noted that Claimant exhibited "markedly decreased breath sounds with poor air exchange," but also determined upon inspection that Claimant's lungs and thorax were "normal with increased respiratory rates." Dr. Hardy's examination of Claimant offers some support to his rationale that Claimant is totally disabled, but it does not overcome the contrary objective medical evidence and more recent diagnoses by qualified physicians which indicate some improvement in Claimant's condition.

In November, 2005, Dr. Repsher examined Claimant and concluded that he showed no evidence of any pulmonary or respiratory disease and is fully fit to perform his coal mining job

duties. *EX 1*. His opinion is supported by objective medical evidence – nonqualifying pulmonary function studies and arterial blood gas studies. Dr. Repsher noted that Claimant has emphysema due to cigarette smoking but determined that it did not rise to the level of total disability. *Id.* His opinion is given more probative value than others because his qualifications are of record. He is the Medical Director of the Occupational and Environmental Lung Disease Program at Lutheran Medical Center in Colorado. *Id.* He has been a B-reader since 1981 and is an associate clinical professor of medicine in the Division of Pulmonary Sciences at the University of Colorado at Denver. *Id.* He has also written numerous articles on pulmonary issues, including the evaluation of disabilities secondary to respiratory disease. *Id*.

Dr. Renn, who also determined that Claimant is not totally disabled due to respiratory impairment, has equally impressive qualifications of record. *EX 4*. He is a B-reader and has served as the Chief of the Pulmonary Function Laboratory and Medical Director of Respiratory Therapy at Monongalia General Hospital and serves as Emeritus Medical staff there today. *Id.* He is also a Department of Energy Physician Panel Member for NIOSH and a pulmonary disease consultant. He has also written several articles and book chapters on pulmonary disease, including one in 2002 on the effects of coal dust.

Dr. Renn's diagnosis that Claimant is not disabled is supported the objective medical evidence of record. His examination of Claimant's medical history is the most recent of record and includes each physician's diagnosis addressed above. Because he looked at the complete record and his diagnosis is supported by objective medical evidence, Dr. Renn's opinion is afforded greater weight. *Minnich v. Pagnotti Enterprises, Inc.,* 9 B.L.R. 1-89, 1-90 n.2 (1986); *Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985).

In conclusion, the opinions of Drs. Repsher and Renn are more in accord with the tests of record than the opinions of Drs. Houser, Evenson, and Hardy. Their examinations are the most recent of record and are better supported by objective medical evidence. Claimant's subjective complaints about his respiratory impairment, both in testimony and in his initial claim, are not enough to overcome the weight of the medical evidence indicating he does not have a totally disabling respiratory impairment.

Entitlement to Benefits

The newly submitted evidence relating to this claim fails to establish the existence of pneumoconiosis by a preponderance of the evidence. Claimant introduced one x-ray interpretation and one medical report indicating that he suffers from coal workers' pneumoconiosis, but both were less probative than the overwhelming evidence that Claimant does not, indeed, have the disease and instead suffers from smoking-related illnesses. The positive x-ray interpretation by a B-reader is less probative than the interpretation of the same x-ray by a dually qualified physician. The lone medical opinion diagnosing Claimant with pneumoconiosis was unsupported by documentation.

Thus, after considering all of the evidence submitted under § 718.202(a), I find that the Claimant has not established the existence of pneumoconiosis by a preponderance of the

evidence. Consequently, Claimant has not demonstrated a change in the applicable condition of entitlement upon which his previous claim was denied.

The newly submitted evidence relating to this claim also fails to establish total disability by a preponderance of the evidence. None of the pulmonary function studies on record qualified to establish total disability because of respiratory or pulmonary conditions. The arterial blood gas studies of record failed to qualify as well. The medical reports that diagnosed Claimant with no disability were by highly qualified physicians and were supported by objective medical evidence. Those reports were also the most recent of record. Claimant's subjective complaints in his testimony and claim do not overcome the medical evidence to the contrary.

In sum, the evidence presented does not establish that the Claimant has pneumoconiosis or that the Claimant's pulmonary condition has worsened since the denial of his previous claim. The Claimant has, therefore, not established a change in an applicable condition of entitlement under 20 C.F.R. §725.309(d). Accordingly, the Claimant's claim must be denied.

ORDER

IT IS ORDERED that the claim for benefits filed by Claimant is denied.

A

John Vittone
Chief Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department

of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).